STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 01/22/2013				
		155230	B. WING			01/22/	2013
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
ROSEBU	JD VILLAGE				HESTER BLVD OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
F0000	Complaint INC Complaint INC Substantiated deficiencies re allegations are F-514.  Survey dates: January 16, 1' Facility numbe Provider number AIM number: Survey team: Angel Tomlins Barbara Gray	0122527 Federal/State elated to the e cited at F-282 &  7, 18, & 22, 2013 er: 000135 per: 155230 100266820  con RN TC RN r RN [January 22, 2013] r/pe:	F000	0	The creation and submission this plan of correction does no constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credib evidence and request a desk review in lieu of post re-certification on or after 2/7/	of n of le	
	Sample: 4						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
		155230	B. WING		01/22/2013
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD	
	ID VILLAGE			OND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	These deficient findings cited in IAC 16.2.			(EACH CORRECTIVE ACTION SHOULD BE	AIE

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Event ID: **77W811** 

Facility ID: 000135

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION			ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155230	A. BUII B. WIN	LDING		01/22/	2013
			D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HESTER BLVD		
DOSEBII	D VILLAGE				OND, IN 47374		
	DVILLAGE			KICITIVI	OND, III 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282	483.20(k)(3)(ii)	HALIEIED DEDCONC/DED					
SS=D	CARE PLAN	UALIFIED PERSONS/PER					
		rided or arranged by the					
		ovided by qualified					
		lance with each resident's					
	written plan of car						
	Based on obse	rvation, interview and	F02	82	F 282 Services By Qualified		02/07/2013
	record review,	the facility failed to			Persons/Per Care Plan The		
	administer ensi	ure plus (nutritional			services provided or arranged	,	
	drink) and a mu	ultivitamin with			the facility must be provided by	-	
	•	mote wound healing			qualified persons in accordance with each resident's written pla		
	•	he physician and an			of care. What corrective	311	
	•	cation and antibacterial			action(s) will be accomplished	ed.	
	medication as				for those residents found to		
		eat osteomyelitis			have been affected by the		
		•			deficient practice? * Resident	t B	
	•	e bone), for 1 of 3			was not negatively affected by		
		wed for pressure ulcers			alleged deficiency. * Resident	В	
	in a total sampl	le of 4 (Resident #B).			receives all medication timely		
					prescribed by physician as		
	Finding include	1:			evidence by the MAR. (See attached MAR.) *The charge		
					nurse will notify the pharmacy,		
	Review of the r	ecord of Resident #B			Director of Nursing and/ or		
	on 1-17-13 at 1	:45 p.m. indicated the			designee if medications do no	t	
		noses included, but			arrive timely. *All new admiss	ion	
	_	d to, transverse			will receive an audit to ensure		
		condary paraplegia			timeliness of medications.		
	•	spinal cord), multiple			*Medications will be STAT	4	
	•	diabetes mellitus,			ordered from pharmacy within hours of an admission. <b>How</b>		
	chronic pain sy				you identify other residents	******	
	•	ndrome and			having the potential to be		
	osteomyelitis.				affected by the same deficier	nt	
	<b>-</b>				practice and what corrective		
	The pressure u				action will be taken. *		
	Resident #B, d	•			Residents who reside in this		
		esident had a new			facility have the potential to be		
	stage one pres	sure ulcer that			affected by the alleged deficie	nt	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155230	B. WIN			01/22/	2013
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					HESTER BLVD		
ROSEBU	JD VILLAGE			RICHM	OND, IN 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)		TAG	practice. * All licensed staff ha	21/0	DATE
		centimeter (cm) long by			been inserviced by the Director		
		e pressure ulcer was			Nursing and/or designee on	0.	
	red with purple	blotches.			proper medication administrat	ion	
					with documentation on 1/24/13	3.	
		note for Resident #B,			(See attached examples of		
		2, indicated the			inservices for nursing staff rela	ated	
	_	etician (RD) requested			to mediacation administration.) *Medication a	udit	
	the resident to	have ensure plus 120			was conducted on 2/6/13 by	GGIL	
	cc two times a	day for 30 days and			Director of Nursing and/or		
	multivitamin wi	th minerals to promote			designee to ensure all		
	wound healing				medications are available as		
					prescribed by physicians. * Sk		
	The physician	order for Resident #B			validations related to medicati administration were completed		
		dicated the resident			all licensed staff on all shifts b		
	was ordered e	nsure plus 120 cc two			the director of nursing and/or	,	
	times a day for	•			designee by 2/7/13. What		
		th minerals every day			measures will be put into pla	ce	
	to promote wo	• •			or what systemic changes yo	ou	
	lo promote wo	and nearing.			will make to ensure that the		
	The Medication	n Administration			deficient practice does not		
		for Resident #B, dated			recur? * Director of nursing and/or designee will conduct		
	, ,	·			rounds on all shifts to monitor	the	
		2, indicated the			timeliness of the medication		
		red ensure plus one			administration pass. * All		
		12 at 4:00 p.m. and did			licensed staff have been		
		ensure plus again until			inserviced by the Director of		
		indicated the resident			Nursing and/or designee on proper medication administrat	ion	
	missed four nu	tritional drinks.			with documentation on 1/24/13		
					*Director of Nursing and	··	
		Resident #B, dated			or/designee will ensure		
	November 201	2, indicated the			physicians orders are initiated		
	resident did no	t receive a multivitamin			when ordered daily. * Skills		
	with minerals u	ıntil 11-26-12. This			validations related to medication		
	indicated the re	esident missed two			administration were completed all licensed staff on all shifts b		
	doses of the n	nultivitamin ordered by			the director of nursing and/or	J	
	the physician.	-			designee by 2/7/13. * The dire	ctor	
	<u> </u>						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2013 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI						
AND PLAN OF C	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155230	B. WIN	G		01/22/	2013
NAME OF PROV	VIDER OR SUPPLIER			2050 CH	ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD OND, IN 47374		
ROSEBUD V  (X4) ID PREFIX TAG  In 1' pr m do ar re th D st th Pr In	SUMMARY ST (EACH DEFICIENCE REGULATORY OR INTERVIEW WITH IT: 10 a.m. indice procedure, for resident occumented in and also documented in an acromatic in a consistency in	che RD on 1-22-13 at cated the facility recommendations she the resident's record rented it on a consheet and gives it to inistrator and the er. The RD indicated contact the physician for DON does.  The center consult for ated 1-10-13, indicated do a stage four (full thickness tissue and the er ated 1-10-13, indicated the red tendon, bone or ring 17 cm long by and 3.5 cm deep on the consult for ated 1-10-13, indicated the resident and the er at long by and 3.5 cm deep on the consult for ated 1-10-13, indicated the resident and the er at long by and 3.5 cm deep on the consult for ated tendon, bone or ring 17 cm long by and 3.5 cm deep on the consult for ated the resident ancomycin (antibiotic) and zosyn 8.375 every 6 hours IV yelitis. The order esident was to have a certed central catheter		2050 CH	HESTER BLVD	on nce er ve ty ut rds erly dit iQI nce	(X5) COMPLETION DATE
(F	PICC) line plac	cement (used to lication) on 1-11-13 at					

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Event ID: **77W811** 

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155230	B. WIN	G		01/22/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DOCEDII	D ) /// L A O E				HESTER BLVD		
KOSEBO	D VILLAGE			RICHINI	OND, IN 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
mo		for Resident #B, dated		ing	<u> </u>		DATE
	•	ted the resident had a					
	· ·	eomyelitis. The					
		rere medications as					
	ordered, PICC	placement as ordered,					
	labs as ordered	d and follow up at					
	wound center a	as scheduled.					
		ote for Resident #B,					
	-						
	vancomycin an	d zosyn.					
	The MAR for R	esident #R_dated					
		·					
	•						
		•					
	_	the resident received					
	her first dose o	f vancomycin on					
		a.m. The MAR					
	indicated the re	esident did not receive					
	zosyn 3.375 gr	ams on 1-11-13 at					
		1-12-13 at 12:00 a.m.					
		ated the resident did					
		first dose of zosyn					
	until 1-12-13 at	: 6:00 a.m.					
	Intonvious with I	Pooldont #P on 1 17 12					
	•						
	-						
	naa an iincollo						
	dated 1-10-13, returned from vorders for PICC 1-11-13. The revancomycin and The MAR for R January 2013 idid not receive grams on 1-11-MAR indicated her first dose of 1-12-12 at 8:00 indicated the receive grams on 1-11-12-13 at 11-12-13 at 11-12-1	indicated the resident wound care center with Cline placement on esident was ordered at zosyn.  desident #B, dated andicated the resident vancomycin 1.25 -13 at 8:00 p.m. The the resident received f vancomycin on a.m. The MAR esident did not receive ams on 1-11-13 at a 1-12-13 at 12:00 a.m. ated the resident did of first dose of zosyn at 6:00 a.m.  Resident #B on 1-17-13 andicated she had a pottom. Resident #B ressure ulcer wound					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  IDENTIFICATION NUMBER:  155230	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	СОМ	E SURVEY PLETED 2/2013
	PROVIDER OR SUPPLIER  JD VILLAGE	2050 C	ADDRESS, CITY, STATE, ZIP COI HESTER BLVD OND, IN 47374	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	During observation on 1-17-13 at 12:10 p.m., Resident #B was receiving a treatment to her pressure ulcer. The resident had a large stage four pressure ulcer on her sacrum. The pressure ulcer color was pink and yellow. The pressure ulcer dressing had a moderate amount of red and brown drainage on it.  Interview with the DON on 1-22-13 at 10:05 a.m. indicated the reason Resident #B did not receive her vancomycin on 1-11-13 and 1-12-13 was because the pharmacy had to mix the medication and had 24 hours to deliver the medication. When queried if the medication was ordered on 1-10-13 wouldn't the medicine already be at the facility on 1-11-13 for the doses missed, the DON indicated that the medication would have been at the facility for administration and she was unsure why the medication was not given on 1-11-13 and 1-12-13.  This federal tag relates to complaint IN00122527.  3.1-35(g)(2)				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER:  155230	A. BUILDING  B. WING	00	COME	E SURVEY PLETED 2/2013
ROSEBU	ROVIDER OR SUPPLIE D VILLAGE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X3) D		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155230	B. WING		01/22/2013
	PROVIDER OR SUPPLIE	ER	2050	T ADDRESS, CITY, STATE, ZIP CODE CHESTER BLVD IMOND, IN 47374	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0514 SS=D	SSIBLE The facility must each resident in professional sta are complete; ar readily accessib organized.  The clinical recomplete information to iddo for the resident's care and service any preadmission the State; and present in the State; and present i	rview and record cility failed to document lication and antibacterial vere given to a resident dents reviewed for rs in a total sample of 4 ).  le; record of Resident #B 1:45 p.m. indicated the gnoses included, but led to, transverse lecondary paraplegia le spinal cord), multiple ), diabetes mellitus, leyndrome and	F0514	F 514 Resident Records- Complete/Accurate/Acces The facility must maintain or records on each resident in accordance with accepted professional standards and practices that are complete accurately documented; reaccessible; and systematica organized. What corrective action(s) will be accomplis for those residents found have been affected by the deficient practice? *Reside receives medications the prescribing physician has on as evidence by the MAR. (Fee attached MAR). *Reside was not negatively affected alleged deficiency. *The charman Director of Nursing and/or designee if medications do arrive timely. *All new adm will receive an audit to ensure the standard of	inical  dily ally shed to ent B rdered Please ent B by the arge cy, not ssion

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE C		JLTIPLE CO	CONSTRUCTION X		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		155230	B. WIN			01/22/	2013	
NAME OF I	DROLUBER OR GURRU IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	C		2050 CI	HESTER BLVD			
ROSEBL	JD VILLAGE			RICHM	OND, IN 47374			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	•	indicated the resident			timeliness of medications. *Medications will be STAT			
		ancomycin (antibiotic)			ordered from pharmacy within	1		
	1.25 grams even	ery 12 hours			hours of admission. How will			
	intravenously (	IV) and Zocyn			identify other residents having	-		
	(antibacterial)	3.375 grams every six			the potential to be affected b	_		
	hours per IV.	-			the same deficient practice a	-		
	'				what corrective action will be	Э		
	Review of the	Medication			taken? * Residents who reside	e in		
		Record (MAR) for			this facility have the potential t	to		
		• •			be affected by the alleged			
		ated January 2013,			deficient practice. * Director o	of		
		esident's zosyn 3.375			Nursing and/or designee will conduct audits of the Medicati	on		
	grams was not signed as given on				Books daily to ensure no	OH		
	1-14-13 and 1-				omissions are found. * All			
	vancomycin 1.	25 grams was not			licensed staff have been			
	signed as give	n on 1-17-13.			inserviced by the Director of			
					Nursing and/or designee on			
	Interview with	the Director of Nursing			proper medication administrat			
		-13 at 10:05 a.m.			with documentation on 1/24/13	3.		
	, ,	dent #B's zosyn was			(See attached examples of	-4 - d		
		-14-13 because the			inservices for nursing staff relation mediacation administration.			
		as clogged up. The			* Skills validations related to	,		
		on 1-16-13 the			medication administration wer	е		
					completed on all licensed staff			
		ceive the zosyn. The			all shifts by the Director of			
		the vacomycin was not			Nursing and/or designee by			
	•	13 due to the resident's			2/7/13 What measures will b	_		
	lab work was h	_			put into place or what system	nic		
		urse who gave the			changes you will make to			
	medication did	not sign the			ensure that the deficient practice does not recur? *			
	medications we	ere given or circle their			Director of Nursing and/or			
	initials to indica	ate the medications			designee will conduct audits o	f		
	were held.				the Medication Books daily to			
					ensure no omissions are found	d. *		
	Interview with	the DON on 1-22-13 at			All licensed staff have been			
		cated the facility's			inserviced by the Director of			
		edications were not			Nursing and/or designee on			
	procedure ii M	eulcations were not			medication administration with	1		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 01/22/2013
	ROVIDER OR SUPPLIER		2050 C	ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD IOND, IN 47374	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION PRIATE DATE
	signed the MAI a circle around of why the med	dent, was the nurse R with their initials and it and an explanation dication was not given.  It relates to complaint		documentation on 1/24/13.  Skills validations related to medication administration we completed on all licensed stall shifts by the Director of Nursing and/or designee by 2/7/13. * The Director of Nursing and/or designee by 2/7/13. * The Director of Nursing and/or compliant related to medication administration. *Non-comp with medication administrat procedures may result in fueducation, and/or disciplina action. How the corrective action(s) will be monitored ensure the deficient practiful will not recur, i.e., what quassurance program will be into place? * A Medical RecQI tool will be utilized by the Director of Nursing and/or designee weekly x 4 weeks monthly x 2, quarterly x 1 for least 6 months. * Audit tool be submitted to the CQI committee and if 95% compis not achieved, action plans be developed.	vill be taff on varsing ce liance ion rther ry ce latto ce lality e put cords he cor

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